DOCUMENT RESUME

ED 137 656 CG 011 241

AUTHOR Aveni, Carl A.; Upper, Dennis
TITLE Training Psychiatric Patients for Community Living.
PUB DATE [May 76]
NOTE 14p.; Paper presented at the Midwestern Association of Behavior Analysis (Chicago, Ill. May 1-4, 1976)

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS Behavior Change; Daily Living Skills; *Educational Programs; *Institutionalized Persons; *Institutional Research; *Interpersonal Competence; *Mental Illness; Patients (Persons); *Psychiatric Hospitals; Skill Development; *Social Adjustment; Social Behavior

ABSTRACT

In this paper, the authors report that in many of the cases they have treated, the living situations and/or environments to which patients were returning upon discharge, were not suitable for either maintaining, or improving upon, the gains achieved while hospitalized. As a result, a community residence training program, based upon a behavioral principles model, was developed and is described. The program targets those patients who appear to have the potential to learn the skills necessary for self-care, with the focus centering around the principle of Successive Approximations. Consistent with this model, and in an effort to establish appropriate expectations during the training process, the program was divided into three separate developmental areas: (1) self-maintenance skills, (2) social-interpersonal skills, and (3) work skills. After four years of training programs and placing several groups, pairs, and even individual patients into the community, continued follow-up reports indicate the success of the program. The authors feel that the continuity of residence in the community for the period of time the original group maintained (ranging from 13 months to four years) as well as the need for less support, is significant evidence that this program works. (Author/YJ)

****
* Documents acquired by ERIC include many informal unpublished *
* materials not available from other sources. ERIC makes every effort *
* to obtain the best copy available. Nevertheless, items of marginal *
* reproducibility are often encountered and this affects the quality *
* of the microfiche and hardcopy reproductions ERIC makes available *
* via the ERIC Document Reproduction Service (EDRS). EDRS is not *
* responsible for the quality of the original document. Reproductions *
* supplied by EDRS are the best that can be made from the original. *
****

ED137656

TRAINING PSYCHIATRIC PATIENTS FOR COMMUNITY LIVING

Carl A. Aveni, ACSW
Behavior Therapy Unit Social Worker

Dennis Upper, Ph.D.
Chief, Behavior Therapy Unit

Veterans Administration Hospital, Brockton, Massachusetts

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

Mailing Address:
Carl A. Aveni, ACSW
89 Manners Ave.
Brockton, Mass., 02401

CG 011241

TRAINING PSYCHIATRIC PATIENTS FOR COMMUNITY LIVING[1]

ABSTRACT

In this paper, the authors report that in many of the cases they have treated, the living situations and/or environments to which patients were returning upon discharge, were not suitable for either maintaining, nor improving upon, the gains achieved while hospitalized. As a result, a community residence training program, based upon a behavioral principles model, was developed and is described. The program targets those patients who appear to have the potential to learn the skills necessary for self-care, with the focus centering around the principle of Successive Approximations.

Consistent with this model, and in an effort to establish appropriate expectations during the training process, the program was divided into three separate developmental areas: (1) self-maintenance skills, (2) social-interpersonal skills, and (3) work skills.

Behaviors which individuals display in these areas, indicating a level of independent living, were identified, each task was introduced to the patients, instructions were given on how to perform the tasks, expectations of how often they were to perform each task were established, and criteria for successful completion were explained. Consistent and accurate feedback in the form of daily rating scales, the use of reinforcers likely to be encountered in the community, and gradually diminished supervision were essential components of the project.

After four years of training programs and placing several groups, pairs, and even individual patients into the community, continued follow-up reports indicate the success of the program. The authors feel that the continuity of residence in the community for the period of time the original group maintained(ranging from 13 months to four years) as well as the need for less support, is significant evidence that this program works.

1. A portion of this paper was presented at the second annual convention of the Mid-Western Association of Behavior Analysis, Chicago, Ill., May 1-4, 1976

TRAINING PSYCHIATRIC PATIENTS FOR COMMUNITY LIVING

Since the opening of the Behavior Therapy Unit at the VA Hospital in Brockton, Massachusetts, a diversified group of patients have gone through the program (i.e. structured token economy, individual and group treatment) and have successfully improved their general level of functioning so as to make them ready to return to community living. Unfortunately, in many cases the living situations and/or environments to which they were returning were not suitable for either maintaining, or improving upon, the gains achieved while hospitalized. As a result, in July of 1972, the staff of the Behavior Therapy Unit developed a community residence training program based on a behavioral principles model. Initially the program targeted those patients considered institutionalized, who lacked the necessary skills or confidence to make a successful independent adjustment in the community, but who appeared to have the potential to learn the skills necessary for self-care. These were patients who had been continuously hospitalized for a number of years and had made unsuccessful adjustments to placements in relatively unstructured foster homes.

The focus of the program centered around the principle of successive approximations, i.e. a step-by-step process of introducing behavioral changes whereby each successive step approximates the desired target behavior slightly more than the step preceding it. This became a series of clearly-defined increasing expectations, in conjunction with consistent feedback and meaningful reinforcers, designed to bring the patients to the point of not only functioning well enough to leave the hospital, but also well enough to be able to live independently in the community. Consistent with the successive approximations model and in an effort to establish appropriate expectations during the training process, the program was divided into three separate developmental areas: (1) self-maintenance skills, (2) social-interpersonal skills, and (3) work skills. Behaviors which individuals should display, indicating a level of independent living were identified and the program centered around learning these behaviors.

The training project itself was an extension, both in method and content,

of the basic token economy system of the BTU and was carried out at the unit level. Coordination of the training became the responsibility of the BTU psychologist and social worker who brought together unit level representatives of most of the services in the hospital. We felt that this multidisciplinary approach would be essential in order to effectively deal with the project's wide range of behaviors and administrative problems. In addition to the BTU's nursing personnel, representatives from the Physical Medicine and Rehabilitation Service, including a group of Occupational Therapy students, and the Dietetic Service were actively involved in the training. This staff formed teams to plan and carry out training courses in each area of the project.

Inpatient Program

A mock-up apartment was established on the BTU for which those patients involved in the training had primary responsibility. This"apartment" included two-bed dorms, which simulated their bedrooms, a small kitchen, bathroom facilities, and the BTU visitor's room which functioned as the "apartment's" living room.

Self-maintenance Skills

For the first training group, four men were chosen who had been in the hospital for several years. They were interviewed by the staff and presented with the idea. In spite of some uncertain feelings about living independently, these four agreed to give the program a try. To facilitate learning to live together, the men were moved into the two-bed dorms which had been furnished with scatter rugs, pictures on the walls, colorful bedspreads, and night tables with individual lamps. Modification of personal grooming habits and simple housekeeping skills were already a part of the BTU token economy program. A program of instruction to teach more advanced housekeeping skills was initiated. In addition to making their own beds, this part of the training included learning how to vacuum rugs, dry mop floors, wash and wax floors when necessary, dust and polish furniture, and the use of several kinds of cleaning and polishing agents, i.e. oven cleaners vs. bathroom disinfectants, for use in specific areas. As each housekeeping task was introduced, the men were given

instructions, expectations of how often they were expected to carry out the task, and criteria for successful completion. The last two points were incorporated into a rating scale, which was used to evaluate their progress during training, as well as their level of performance later on in the community. The men took turns doing a different area each week to give each of them as much exposure as possible in all areas of housekeeping chores. They were checked and rated by the ward janitor and nursing assistants who helped them until they learned these skills at an acceptable level.

Instruction in food preparation began with discussions of the kinds of foods the men liked, nutritional necessities, and cooking and food in general. This was followed by lessons in simple menu planning, food shopping, and basic cooking techniques. Direct involvement in these activities began by planning one meal(lunch), shopping for the food, and cooking it on the ward. As with the housekeeping chores, each of the men took turns at shopping for the food, preparing the meal, and cleaning up afterwards. Training systematically progressed to the point where the men collectively prepared menus for five or six main meals, translated these menus into a shopping list, purchased the week's food supply, and prepared the meals in the unit's kitchen.

Clothing care skills began with general discussions about the different fabrics and the kinds of cleaning techniques used for each of them, including cleaning and bleaching agents. Training sessions involved cleaning clothes at local laundromats and dry cleaners and developing adequate wardrobes. Training went into specifics such as sorting of clothes according to washing instructions, stain removal, washing vs dry cleaning, and iron vs no-iron clothes. The second phase of this training segment involved learning to make minor clothes repairs. The men were taught how to sew on buttons, fix small tears, and how to repair or replace zippers.

Transition to independent living requires a person to engage in a variety of interactions with people in the community in order to acquire needed services or products which our patients had come to expect as part of the hospital's services. The

men had learned how to get along in the hospital, but needed to learn the skills necessary to transact business in the community. For example, the men had to learn how to use a bank in order to manage their money. For some in the group, it was the first time they had written checks and had taken responsibility for their own funds. Since most of the men were on fixed limited incomes, they were taught how to budget their money, buy in quantity and on sales, and how to keep track of their funds.

Since they all had been hospitalized for several years, they had learned to ask for simple medication, such as aspirin or cold medications, from the ward nurse. They were taught how to use a drug store and what could be found there. They were also taught the differences in stores and where to look for specific items.

The essentials of using public transportation(buses, trains, taxis) were taught, as well as how to get help in an emergency(ranging from a flooded bathroom to a fire to a medical/psychiatric emergency). In addition to identifying and providing training for these specific skills and activities, the staff assisted the group in preparing for their new roles by role-playing situations they would encounter.

Social-Interpersonal Skills

One of the principal goals of the inpatient training program was the establishment of a meaningful social unit which would promote interpersonal patterns quite different from those associated with "institutional patients." It was felt that the ability to approach others and to cooperate with others are necessary skills if a person is to assume self-responsibility. Each man's willingness to interact with the people with whom he lives and to become involved with his environment became an aim of this program. While in most cases, tasks might be carried out by one or two residents, decisions about the tasks and responsibility for completion of the tasks were shared by the entire group. Rather than establish the expectation that each individual independently be able to display these interpersonal skills upon discharge, we established the goal that the men be able to exhibit these skills as a group. Therefore,

we designed the program so that the men would function as a group, whenever possible. This was done to supply support and direction. All activities and training courses were structured in order to promote the group experience and most decisions with regard to the project were shared with or made by the group. Group meetings were organized around the problems which they could encounter in the community. In addition to evaluating each of the men's preparedness in terms of his performance on the various BTU rating scales(i.e. use of free time and pro-social), their participation in these group meetings was evaluated in terms of the level of group decision making.

We found that the group experience did supply support and direction to the men, while offering a means by which we could modify their dependency upon the hospital. Although the hospital remained an important part of their world, their dependency shifted for the most part to another, much more appropriate, social unit, i.e. their group. Furthermore, in line with previous research on groups of chronic patients, the men not only formed a cohesive group, but were also capable of making responsible decisions. By restructuring their social activities(i.e. shifting of a reliance upon the hospital for recreation and social support to an orientation toward the community) we were able to solidify this modification in their behavior.

Work Skills

A review of literature pertinent to in-hospital training programs indicated that the most successful programs have stressed the importance of participation in a meaningful work experience. A work assignment provides an activity to fill hours usually spent in hospital dayrooms and canteens. A meaningful activity in which the person becomes personally involved also provides an opportunity for the development of self-confidence, useful job skills and habits, and the status necessary for moving comfortably within the community. We also wanted to use the hospital assignments and the relationships the men had established with work supervisors and fellow workers as a means of establishing continuity between the inpatient and community aspects of our project. Therefore, prior to the start of the inpatient training program, we

made certain that each man was assigned to a job which would provide a meaningful work experience. These were assignments at which the men could continue to work after discharge and, in most cases, these jobs provided financial incentives. In those instances in which a transition was attempted from a sheltered workshop setting to competitive employment, it was not encouraged until the resident had demonstrated an ability to function adequately in all areas of the community program.

Observation, Feedback, and Reinforcement

Essential components of our project to shape behaviors necessary for self-care through the use of successive approximations were consistent and accurate feedback, as well as the use of reinforcers which the men were likely to encounter in the community. The feedback system provided a powerful source of reinforcement, which was complemented by the frequent use of social reinforcers from the staff and within the group, special recognition from the other residents on the unit, and monetary rewards.

During the inpatient training program, we attempted to closely monitor and provide accurate feedback in each area of skill training. The instruction in self-maintenance skills involved direct staff-patient interaction and provided the opportunity for informal feedback and social reinforcement. Housekeeping and clothes care training adapted easily to a system of observation and feedback using rating scales. These scales were then available for monitoring the men's performance in the community. The cooking classes of course, provided their own immediate feedback. We continued to use the work performance scale which is part of the basic behavior modification program on the unit. The men's performance at their work assignments were rated twice a day by their supervisors, and their week's ratings were then used to determine the amount of spending money they receive each week.

Our initial plans for the community phase of the project included an expanded use of money as a reinforcer. The amount of spending money for things other than food, rent, and utilities was to be determined by the men's work performance and success at maintaining their residence. However, we later learned that as VA employees, we were

prohibited from managing outpatient funds and were thus put into the position of relinquishing these plans. Financial incentives were still available in the hospital work assignments and we believe that careful attention to the selection of appropriate behavior and reinforcers during the inpatient program necessitates less stringent control in the community.

Supervision

When we first developed the training program, the issue of greatest concern was the control and supervision of the men's behavior in the community. It was our feeling at that time, and has remained so up to the present time, that a community residence with a behavioral orientation allows for an experience of structured community living without direct supervision. Some type of supervision is needed to provide the direction and emotional support which the hospital had supplied the chronic patient. Confidence with which to live in the community, however, requires experience in living independently from the hospital. These needs were met by supplying absentee supervision within a structured, group-oriented program and by gradually increasing the demands placed upon the residents to assume personal responsibility.

When the men entered the community, they had available the following sources of supervision: (1) weekly group meetings with the unit social worker in which there were discussions about the weekly menus, all financial matters including the use of spending money, personal and group ratings, social activities, and any problems the men might have expressed in the daily communications log that they left at the unit each day: (2) on-site visits by staff at which time some of the ratings were made: (3) daily encounters with work supervisors: and (4) regularly scheduled outpatient visits for medication follow-up.

If problems occurred which could not be handled by the group, the following procedures were available, depending upon the severity of the problem: (1) phone conversations with unit personnel available on a 24 hour basis: (2) visits to the unit for discussion with the staff: and (3) temporary hospitalization on the BTU.

The Residence

Our original goal was to furnish a house or apartment which could serve as a temporary home for four to six men. The availability of such a residence to the BTU on a permanent(probably rental) basis would have minimized the financial investment of each resident upon transition to the community and would have allowed us flexability in the placement of men. Such an arrangement requires financial backing which was not available to us. We therefore decided to establish separate groups of men, each of which would collectively rent and furnish an apartment.

The apartment which the first group of men rented is a modern, two bedroom apartment in a pleasant residential section of Brockton, near the hospital. All the furniture was donated by people outside the hospital, except for the beds and television, which the men purchased themselves. Contact with volunteer groups within the community led to the donation of the used furniture, which aided later groups in moving into the community a little bit quicker because of the stockpiling of excess furniture.

Where We Are At

Almost four years have passed since the first group of men moved into the community. Since then, several other groups, pairs, and even individual patients have gone through the training program and into the community. We originally planned to establish expectations for further movement toward greater self-responsibility. The men were to seek housing which would be completely independent from the hospital. In many cases, the halfway house programs which have not placed time limits on the residents have become permanent homes. As our project evolved, however, the concept of a time limit changed. Because the men have had their own apartment from the beginning, we did not have to move the men out to create an independent residence. We only needed to gradually withdraw supervision.

Of the original four men placed into the community, one has remained in the apartment for four years, and functions as a semi-official manager. A second man has moved on to another apartment and asked us to train more men to live with him. The

third member of the original group died of a medical condition a little over one year after moving into the apartment. This particular man had been hospitalized continuously for 15 years prior to our placing him out and had been declared incompetent to handle his affairs. About four months prior to his death, and based upon his adjustment in the community, his legal status was changed to where he became responsible for his own affairs once again. The fourth member of the original group was rehospitalized after 18 months, for medical reasons.

We feel that the continuity of residence in the community for the period of time the original group maintained(ranging from 13 months to four years) as well as the need for less support, is significant evidence of the success of the project. At present, the men in the original apartment(we trained new men and filled in the vacancies) are functioning as a fairly autonomous group. They continue to visit the unit on occasion, but these increasingly took on the form of more traditional follow-up outpatient visits.

The final phase of transition to the community is competitive employment outside the hospital. One of the men in the original group has made this transition and is working in a factory in a nearby town while taking evening courses to get a better job. We realized from the start that not all the men would achieve this goal, however, if appropriate sheltered work settings were available outside the hospital, the men could move even further into the community.

Unfortunately, success in our society is often judged in terms of economics, but we feel our project has succeeded here, too. The men pay approximately $96 per month per man for rent, utilities, and food. This compares to $180 to $200 per month for similar services in a foster home in the Brockton area. This difference allows the men to draw an additional $21 per week for spending money to cover transportation, laundry, entertainment, and other miscellaneous items without paying more than they would for food and lodging if they were not self-sufficient. Perhaps the fact that the men have begun savings accounts in addition to checking accounts is a fitting way to demonstrate the extent of their success in moving from institutional-

ization to self-responsibility in the community.

References

Bowen, W.T., and Fry, T.J.,"Group Living:a Social Approach to a Social Problem?" Unpublished manuscript, 1971

Bowen,W.T., and Fry, T.J., "Group Living in the Community for Chronic Patients" Hospital and Community Psychiatry,1971, 22(7), pp. 29-30

Fairweather, G.W., Sanders, D.H., Cressler, D.L., and Maynard, H., Community Life for the Mentally Ill: an Alternative to Institutional Care., Aldine Publishing Company, Chicago, 1969

Hickey, R.H., "Poker Chips and Lodges," Behavior Modification in Outplacement Settings, Upper, D., and Goodenough, D.(Eds.) Roche Laboratories, Nutley, N.J., 1971

Huessey, H., "Beyond the Halfway House", International Journal of Social Psychiatry, 1969, 15(3), pp. 235-239

Lamb, H.R., and Goertzel, V., "Discharged Mental Patients: Are They Really in the Community?" Archives of General Psychiatry, 1971, 24, pp. 29-34

Malloy, P. "Transitional Housing for the Mentally Disturbed," Unpublished Manuscript, 1972

Paul, G.L., "Chronic Mental Patients: Current Status--Future Directions," Psychological Bulletin, 1969,17,pp. 81-94

Sanders, D.A., "Innovative Programs in the Community Treatment of Mental Illness. Transitional Facilities in the Rehabilitation of the Emotionally Disturbed, Sinnett, E.R., and Sachson, A.D.(Eds.), University Press of Kansas, 1970